

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-038075

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District **1003** Primary Registration District No. **9564** Registrar's No.

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Lemay	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Alexian Bros. Hospital		d. STREET ADDRESS (If outside, give location) 763 Ruprecht	
3. NAME OF DECEASED (Type or print) First Anna Middle T. Last Strocher		4. DATE OF DEATH Month September Day 23 Year 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/9/1902
9. AGE (last birthday) 61		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Casper Machino		13b. MOTHER'S MAIDEN NAME Catherine Dolan	
14. NAME OF HUSBAND OR WIFE Fred		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Fred Strocher 763 Ruprecht, Lemay, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral thrombosis generalized arteriosclerosis. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) 332X		INTERVAL BETWEEN ONSET AND DEATH 2 hours.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Parkinson's Disease. Chronic bladder ulcer.		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION Lemay, Missouri		
21. I attended the deceased from 1954 to death and last saw her alive on 9 22 63 Death occurred at 8 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE John G. Kellett M. D.		22b. ADDRESS 314 Telegraph Road. Lemay Mo.	
22c. DATE SIGNED SEP 24 1963		22d. LOCATION (City, town, or county) (State) Lemay, Missouri	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Sept. 26, 1963	23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery	
23d. FUNERAL DIRECTOR C. Hoffmeister Mortuaries		23e. ADDRESS 7814 So. Broadway St. Louis, Mo.	
25. DATE RECD. BY LOCAL REG. SEP 24 1963		26. REGISTRAR'S SIGNATURE Paul Smith M.D.	

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Louis C. Hoffmann

Licensed Embalmer No. 3871

P. O. Address 504 W. Ripa

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.